Michigan Medicaid Database Explanation for Ancillary Services
March 2002

This document contains information for interpreting the Michigan Medicaid Databases listed for ancillary services. Each database contains the covered services for each provider group, a short description, a status code, designated modifiers, limits indicator, prior authorization indicator, and established fee screens. The databases available by provider group are:

- Medical Suppliers/DME Dealers/Orthotists/Prosthetists
- Hearing Aid Dealers
- Hearing and Speech Centers

The databases are in two formats:

- PDF excel file for viewing and/or printing a page
- WINZIP self-extracting executable Excel file for downloading data into your computer

The database for Medical Suppliers/DME Dealers/Orthotists/Prosthetics include the following data elements:

- HCPC or Medicaid Local Procedure Code active for 2/1/02
- Modifier
- LT/RT Modifier
- Code Description
- Status Code
- Michigan Medicaid Fee Screen effective 2/1/02
- Limits (Maximum Units) Indicator
- Age Limits
- LTC Per Diem Rate
- ABC Certification .(Applies to Orthotists/Prosthetists Only)
- Prior Authorization (PA) Indicator
- PA Age Limits
- Diagnosis Exception Codes for PA

The databases for Hearing & Speech Centers and Hearing Aid Dealers include the following data elements:

- Procedure Code active for 2/1/02
- Code Description
- Status Code
- Michigan Medicaid Fee Screen effective 2/1/02
- Limits (Maximum Units) Indicator
- Prior Authorization (PA) Indicator
- Age Limits

The file contains one record for each unique combination of procedure code and modifier and is sorted in ascending order.

Questions on the database should be directed to Provider Inquiry by phone at 1-800-292-2550 or email to ProviderSupport@state.mi.us Include your name, affiliation and phone number for contact information.

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Data Element	Description
HCPCS or Medicaid Local code	HCPCS Level 2 or Michigan Local code number for the service. The DME/medical supplies, orthotics and prosthetics program uses the following section from the HCPCS coding system: • A codes – Medical and Surgical Supplies and miscellaneous • B codes – Enteral and Parenteral Nutrition • E- codes – Durable Medical Equipment • K codes – Temporary Codes • L codes - Orthotic and Prosthetic devices • S codes – Temporary Codes • Y codes – Michigan Medicaid Local codes
Modifier	The following modifiers identify a set fee screen. For medical supplies, LA = (Large) child diaper LB = Long Term Use of a Specialized Bed LF = (Lofric) intermittent urinary catheter, straight tip LG = (Large) Adult Diaper MD = (Medium) Adult Diaper PR = Addition of Power Recline PS = Addition of Power Tilt-in-Space PT = Addition of Power Recline and Tilt-in-Space SB = Short Term Use of a Specialize Bed SM = (Small) Adult Diaper TR = (Therevac) single unit enema WW = Size Small WX = Size Medium WY = Size Large XL = (Extra Large) Adult Diaper) YD = Youth diaper For durable medical equipment, CS = Custom Seating For Wheelchairs LB = Long Term Use of a Specialized Bed PR = Addition of Power Recline to a Wheelchair Base PS = Addition of Power Tilt-in-Space to a Wheelchair Base\ PT _ Addition of Power Recline and Tilt-in-Space to a Wheelchair Base RP = Replacement and repair RR = Rental (use when DME is to be rented) SB = Short Term Use of a Specialized Bed WD = Extremely Heavy Duty: Can support client weighing > 350 lbs. WE = Extra Wide and Extremely Heavy Duty: can support patient weighing >350 lbs. and has seat width of >22”. Y3 = Footwear Code for Additional Charge for Split Size For orthotics and prosthetics: RP = Replacement and repair **A blank will appear for services other than those identified above and designates a purchase.**

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Data Element	Description
LT/RT Modifier	For orthotics and prosthetics, the "LT" and "RT" modifiers are required to designate either the left or right side of the body if applicable. To determine whether a procedure code requires a "LT" or "RT", refer to the Medicaid Ancillary Database. LT = Left Side of the Body RT = Right Side of the Body
Code Description	The description of the service identified by the code number.
Status Code	Indicates if a code is active (covered) when the database is published and whether additional information is required. A= Active code 2/1/02 M= Additional information is required with the claim
Maximum Fee	Represents the maximum fee screen Medicaid will pay for the service provided. If the fee is $0.01, it is individually priced.
Limits Indicator	The limits or maximum allowable indicator means the maximum quantity of an item that may be reimbursed within the time frame indicated unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized is dependent on medical necessity as determined through the PA process.
Age Limits	Age range in which coverage of the item is considered.
Prior Authorization (PA) Indicator	Indicates "Y" if item requires PA and "N" if no PA is required.
PA Age Limits	Indicates the age in which PA is required.
Diagnosis Exception Codes for PA	Indicates the diagnoses codes representing medical conditions that bypass the PA requirement.
LTC Per Diem	Indicates "Y" or "N" as to whether the item is considered as part of the Long Term Care Per Diem Rate. If "Y" is indicated, the item should not be billed by the medical supplier.
ABC Certification Indicator	Indicates "Y" or "N" as to whether ABC Certification is required to provide service (Applies to Orthotic or Prosthetic appliances only with DOS on or after 4/1/02).